New Hampshire

NH Medicaid PDL Non-Preferred Drug Approval Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

First Health Services

Date of Medication Request: ___ ___ /___ ___ /___ ___ ___ ___

PLEASE NOTE:
The following drug classes require separate clinical prior authorization: Anti-Obesity agents, Receptor selective NSAID medications, Onychomycosis agents, Proton Pump Inhibitors, Rheumatologic Agents, and CNS Stimulants. Please use the class specific form for these drug classes, found on the DHHS website, at:
http://www.dhhs.nh.gov/DHHS/MEDICAIDPROGRAM/LIBRARY/Form/pdl-prior-authorization-form.htm

SECTION I: Patient Information and Medication Requested

Name: (Last, First) _____ Medicaid Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name: _____ Strength: _____

Dosing Directions:_____ Length of Therapy: _____

SECTION II: Non-Preferred Drug Approval Criteria

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria:

☐ Allergic reaction ☐ Drug-to-drug interaction. Please describe reaction: _____

_____

☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____

_____

_____

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information: _____

_____

☐ Age specific indications. Please provide patient age and explain: _____

_____

☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference:

_____

_____

☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____

_____

_____

SECTION III: Prescriber Information

Name: _____ DEA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone #: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax #: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider